

EXHIBIT 1

**WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES
BUREAU FOR PUBLIC HEALTH - VITAL REGISTRATION
PHYSICIAN'S/MEDICAL EXAMINER'S CERTIFICATE OF DEATH
350 CAPITOL STREET, ROOM 165, CHARLESTON, WV 25301**

011835

STATE FILE NUMBER

TYPE/PRINT
IN
PERMANENT
BLACK INK

1. DECEDENT'S NAME (First, Middle, Last) Drema June Ashley		2. SEX F	3. DATE OF DEATH (Month, Day, Year) 7/8/2017
4. SOCIAL SECURITY NUMBER 236-70-2786	5a. AGE-Last Birthday (Years) 74	5b. UNDER 1 YEAR Months: Days: Hours: Minutes:	5c. UNDER 1 DAY Hours: Minutes:
6. DATE OF BIRTH (Month, Day, Year) 7/8/1943			
7. BIRTH PLACE (City and State or Foreign Country) Varetha, WV			
8a. PLACE OF DEATH (Check only one: see instructions on other side) <input checked="" type="checkbox"/> HOME <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify)			
8. WAS DECEDENT EVER IN U.S. ARMED FORCES? (Yes or No) NO			
9a. FACILITY NAME (If not institution, give street and number) 190 Oakland Ave		9b. CITY, TOWN, OR LOCATION OF DEATH Smithers	
10. MARITAL STATUS—Married, Never Married, Widowed, Divorced (Specify) Widowed		11. SURVIVING SPOUSE (If wife, give maiden name) Homemaker	
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired.) 901 Own Residence		12b. KIND OF BUSINESS/INDUSTRY 989	
13a. RESIDENCE—STATE WV	13b. COUNTY Fayette	13c. CITY, TOWN, OR LOCATION Smithers	13d. STREET AND NUMBER 120 Oakland Ave.
13e. INSIDE CITY LIMITS (Yes or No) YES	13f. ZIP CODE 25186	14. WAS DECEDENT OF HISPANIC ORIGIN? (Specify No or Yes—if yes, specify Cuban, Mexican, Puerto Rican, etc.) NO	15. RACE—American Indian, Black, White, etc. (Specify) White
16. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary School (8-12) 15 College (13-16) 16 Graduate (17-18) 17		17. FATHER'S NAME (First, Middle, Last) Henry Prather	
18. MOTHER'S NAME (First, Middle, Last) Ethel Gray		19a. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) PO Box 68 Gawayley Bridge WV 25085	
19b. INFORMANT'S NAME (Type/Print) Larry Be Prather Sr.		20a. PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) Bethel Cemetery	
20b. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20c. LOCATION—City or Town, State POC, WV	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE OR PERSON ACTING AS SUCH Debra Sanders		22. NAME AND ADDRESS OF FACILITY Pennington Funeral Home PO Box 689 Gawayley Bridge WV 25085	
23a. To the best of my knowledge, death occurred at the time, date, and place stated.		23b. DATE SIGNED (Month, Day, Year) 7/12/17	
24. TIME OF DEATH Mid P.M. 7/8/17		25. DATE PRONOUNCED DEAD (Month, Day, Year) 7/8/17	
26. WAS CASE REFERRED TO MEDICAL EXAMINER/CORONER? (Yes or No) YES 17-3399		27. PART I. Enter the diseases, injuries, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Arteriosclerotic cardiovascular disease	
IMMEDIATE CAUSE (Final disease or condition resulting in death) Arteriosclerotic cardiovascular disease		28. WAS AN AUTOPSY PERFORMED? (Yes or No) NO	
Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (disease or injury that initiated events resulting in death) LAST Hypothyroidism		29b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or No) NO	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypothyroidism		29. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be Determined	
30a. DATE OF INJURY (Month, Day, Year)		30b. TIME OF INJURY M	30c. INJURY AT WORK? (Yes or No)
30d. DESCRIBE HOW INJURY OCCURRED		30e. PLACE OF INJURY—At home, farm, street, factory, office building, etc. (Specify)	
30f. LOCATION (Street and Number or Rural Route Number, City or Town, State)		31a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN OR QUALIFIED APRN (Physician or qualified Advanced Practice Registered Nurse certifying cause of death when another physician has pronounced death and completed item 29) To the best of my knowledge, death occurred due to the cause(s) and manner as stated. <input type="checkbox"/> PRONOUNCING AND CERTIFYING PHYSICIAN OR QUALIFIED APRN (Physician or qualified Advanced Practice Registered Nurse both pronouncing death and certifying cause of death) To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER/CORONER (On the basis of examination and/or investigation, in my opinion, death occurred at the time, date, and place, and due to the cause(s) and manner as stated.)	
31b. SIGNATURE AND TITLE OF CERTIFIER Piotr Kubiczek, M.D. Deputy Chief Medical Examiner		31c. DATE SIGNED (Month, Day, Year) 7/12/17	
32. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print) Piotr Kubiczek, M.D., 619 Virginia St. W., Charleston, WV 25302		34. DATE FILED (Month, Day, Year) JUL 18 2017	
33. REGISTRAR'S SIGNATURE Ramona Fox			